Washington State Department of Health

Other Condition

LHJ Use ID _____
LHJ Classification ☐ **Confirmed** ☐ **Probable**
By: ☐ **Lab** ☐ **Clinical** ☐ **Epi Link:** _____

Disease:

County:

REPORT SOURCE

LHJ notification date ___/___/___
Investigation start date: ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Zip code (school or occupation): _____ Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino ☐ Unk
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other ☐ Unk

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness
☐	☐	☐	☐	Autopsy

Death date ___/___/___
Place of death _____

Laboratory

Specimen type _____ Specimen type _____
Collection date ___/___/___ Collection date ___/___/___

NOTES

Answers are: Yes, No, Unknown to case, Not asked /Not answered

Case Name: _____

EXPOSURES

Y	N	DK	NA	
☐	☐	☐	☐	Travel out of the state, out of the country, or outside of usual routine Out of: ☐ County ☐ State ☐ Country Dates/Locations: _____ _____ _____
☐	☐	☐	☐	Case knows anyone with similar symptoms

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

Exposure details: _____

☐ **No risk factors or exposures could be identified**

☐ **Patient could not be interviewed**

PUBLIC HEALTH ISSUES	PUBLIC HEALTH ACTIONS

NOTES

Investigator _____ **Phone/email:** _____	**Investigation complete date** ___/___/___
Local health jurisdiction _____	**Record complete date** ___/___/___